Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
San Antonio Injury Rehabilitation

Respondent Name
City of San Antonio

MFDR Tracking Number
M4-08-1470-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
November 1, 2007

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Billed for 6 different ranges of motion (units), ins paid 1 unit. Per TDI-DWC multiple units of Range of Motion testing are allowed to be billed and payment expected."

Amount in Dispute: $108.72

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: It appears based on the available information that the charges were reduced in accordance with the fee guidelines.

Response Submitted By: Harris & Harris, 5900 Southwest Parkway, Building 2, Austin, TX 78735

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 8, 2007	95861	$108.72	$108.72

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.202 sets out the fee guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 131 – Claim specific negotiated discount
   - DO – Payment is denied as our records indicate that this is an exact duplicate charge for a service that has already been paid or is in process.

Issues

1. Are the services in dispute subject to a contract?
2. Did the requestor support additional payment is due?
3. What is applicable rule to determine fee guidelines?

4. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code d) In all cases, reimbursement shall be the least of the: (1) MAR amount as established by this rule; (2) health care provider's usual and customary charge; or, (3) health care provider's workers' compensation negotiated and/or contracted amount that applies to the billed service(s). The carrier denied the disputed charges as 131 - "Claim specific negotiated discount." No documentation was provided in regards to support that a reimbursement rate was negotiated between the worker's compensation insurance carrier and the health care provider prior to the services being rendered; therefore 28 Texas Administrative Code §134.202(d)(3) does not apply. The services in dispute will we reviewed per applicable fee guidelines.
2. 28 Texas Labor Code §134.202(b) (adopted to be effective January 5, 2003, 27 TexReg 4048 and 12304), states in pertinent part, "For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section. Review of the submitted medical claim finds the following;
    a. Code 95851 has a description of: "Range of motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine).
    b. Review of the medical documentation finds supporting evidence the number of units is supported.
3. 28 Texas Labor Code §134.202(1) states in pertinent part, "for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%." The Maximum Allowable Reimbursement (MAR) is $16.89 x 125% = $38.00 per unit x 6 units = $228.
4. The total recommended payment for the services in dispute is $228. This amount less the amount previously paid by the insurance carrier of $17.94 leaves an amount due to the requestor of $210.06. The requestor is seeking $108.72. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $108.72.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $108.72, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	August 28, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.